Appendix A—Schedule of Events

Event	Date
Release RFP	02/14/2001
Deadline for Written Questions*	03/06/2001
Optional Bidders' Conference/Two Delegates Maximum**	03/09/2001
Transcript of the Bidders' Conference and Bidder Q&As will be Posted on the Internet at www.gagta.com and at www.communityhealth.state.ga.us	03/14/2001
Intent to Bid Letter	03/16/2001
Proposals Due***	04/19/2001, 2:00 PM EST
Technical Evaluation	04/19/2001–05/14/2001
Top Three /Oral Presentations (if needed)	Week of 05/14/2001
Top Three/ Vendor Demo Site Visits	Week of 05/21/2001
Cost Evaluation Complete by GTA/Mercer	05/25/2001
Contract Award Date (on/about)	05/30/2001
Phase I Implementation—Medicaid/PeachCare for Kids	10/01/2002
Phase II Implementation—SHBP	07/01/2003
Phase II Implementation—BORHP	01/01/2004

Please submit questions via e-mail to: ***bshepard@gagta.com***

**Participation in the Bidders' Conference is limited to only two people attending from each Bidder or subcontractor.

***Proposals must be delivered to the following address no later than 2:00 PM EST:

Georgia Technology Authority
100 Peachtree Street, Suite 2300
Atlanta, Georgia 30303-3404

Appendix B—Directions to Bidders' Conference

Location to the Bidder's Conference will be announced in an amendment to the RFP.

Appendix C—Acronyms and Definitions

Acronyms

BOR	Board of Regents of the University System of Georgia
BORHP	Board of Regents Health Plan
CO	Contracting Officer
COAR	Contracting Officer Administrative Representative
CY	Calendar Year
DCH	Department of Community Health
DHR	Department of Human Resources
DOAS	Department of Administrative Services
DSS	Decision Support System
ESI	Express Scripts Incorporated
GRITS	Georgia Registry and Immunization Tracking System
GTA	Georgia Technology Authority
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
IT	Information Technology
O.C.G.A.	Official Code of Georgia (State Statutes)
PBM	Pharmacy Benefit Manager
RFP	Request for Proposal
SHBP	State Health Benefit Plan
SFY	State Fiscal Year
SOW	Statement of Work

Definitions

Agency—Any and all State of Georgia departments, agencies, authorities, commissions, board, colleges, and universities.

Best Value—The expected outcome of an acquisition that, in the State's estimation, provides the greatest overall benefit in response to the requirement. Highlights the importance of technical merit and/or performance of an offer to satisfy a particular requirement, relative to the importance of the price paid to satisfy a particular requirement.

Bidder—A vendor who returns a properly completed bid in response to a request for solicitation from an authorized state or agency purchasing agent.

Can, May, Should—Used to express nonmandatory provisions; words denote the permissive.

Clean Claim/Complete Claim Definition—"Complete Claim" means a claim for charges that is not in dispute, is not missing any information necessary to process said claim, is not under appeal as to the benefit entitled for such claim, or does not involve coordination of benefits, third party liability or subrogation, and is represented by a properly completed billing form (UB-92 and HCFA 1500 or an electronic equivalent) with complete coding submitted in accordance with the directions of the DCH/BOR and the Claims Administrator.

Contract Administration—The management of all actions that must be taken to assure compliance with the terms of the contract after award.

Contracting Officer (CO)—Any person who is authorized to take actions on behalf of the GTA to enter into a contract; amend, modify or deviate from the contract terms, conditions, requirements, and specifications; terminate the contract for convenience or default; and to issue final decisions regarding contract questions or matters under dispute. The CO may delegate certain responsibilities to his/her authorized representatives.

Contracting Officer Administrative Representative (COAR)—Any person who is designated to assist in the administration of the contract or to assist the CO in the discharge of his/her responsibilities.

Contractor or Vendor—Any responsible source that provides a supply or service to GTA.

Desirable Requirements—Specific elements that would be nice to have but are not considered critical or essential for delivery of the goods or performance of the services.

Evaluation—The in-depth review and analysis of contractors' proposals. It involves the application of judgment to the contractor's proposed price and performance using the express evaluation factors and criteria in the solicitation and the procedures outlined herein. The purpose of evaluation is to identify deficiencies, omissions, and need for clarification in proposals, determine the existence of price and technical realism, and discriminate among proposals as to which best meets the acquisition objectives so that an appropriate selection and award is made.

Information Technology (IT)—Any equipment, or interconnected system(s) or subsystem(s) of equipment, that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the agency.

IT includes computers, ancillary equipment, software, firmware, and similar procedures, services (including support services), and related resources.

Mandatory Requirements—The minimum or basic elements that are absolutely essential to the requirement must be clearly identified in the solicitation document.

Offeror—Vendor responding to this request for proposal.

Request for Proposal (RFP)—A solicitation used when discussions may be required prior to contract award; a document used for soliciting competitive proposals.

Shall, Must, Is Required—Used to express a requirement binding on either the vendor or the purchaser; words denote the imperative.

Solicitation—A request to prospective vendors soliciting price quotation or proposal. Contains, or incorporates by reference, the specifications or statement of work and all contractual terms and conditions.

Statement of Work (SOW) or Scope of Services—A document prepared by the requester and included in the requisition package, which delineates and fully describes the service to be performed or the required end result.

Statutes—Laws passed by Congress or a state legislature and signed by the President or the governor of a state, respectively, that are codified in volumes called "codes" according to subject matter.

Will—Used to express a declaration of purpose on the part of the purchaser.

Appendix D—State Health Benefit Plan (SHBP)
Program Description and Statistics

Program Description:

The State Health Benefit Plan (SHBP) is an umbrella health benefit plan for employees of state government and the local school systems. The Plan is authorized under Article 1 of Chapter 18 of Title 45 and Part 6 of Article 17 of Chapter 2 of Title 20 of the Official Code of Georgia.

Background:

As of July 1, 1999, the administration of the plan was transferred from the Georgia Merit System to the Department of Community Health. At the same time, the policy-making functions were transferred from the State Personnel Board to the Board of Community Health.

Funding:

There are four types of funding options for the SHBP:

1. Three HMO options that are fully insured
2. Preferred Provider Options (PPO) that represent a self-insurance arrangement
3. High Option Indemnity Plan that is a self-insured product
4. Consumer Choice Options (PPO and Indemnity)

Summary of Benefits:

See following pages.

External Vendors:

- Utilization Management
- Behavioral Health
- Prescription Drug
- PPO Network(s)
- Third Party Administrator

Schedule of Benefits
Benefits For You and Your Dependents

Covered Services	July 1, 2000 High Option Plan The Plan Pays:	Standard PPO Plan In-Network The Plan Pays:	Standard PPO Plan Out-of-Network The Plan Pays:
Primary Care Physician or Specialist Office or Clinic Visits ▪ Treatment of Illness or Injury	90% of UCR; subject to general deductible.	100% of network rate after a per visit copayment of $20; not subject to general deductible.	60% of UCR; subject to general deductible.
▪ Wellness Care (preventive health care) ▪ Well-Newborn Exam ▪ Well-Child Exams and Immunizations ▪ Annual Physicals ▪ Annual Gynecological Exams	$100 per person per year, $75 for mammographies; no deductible; office visits excluded. Well Care service limited to certain test and immunizations.	100% of network rate with no copayment for associated lab and test charges up to a maximum of $500 per year (at network rate). Not subject to general deductible; to include such services as mammograms, PSAs, EKGs, and pap smears; covered according to age schedules and medical history.	Not covered. Charges do not apply to general deductible or annual out-of-pocket (stop-loss) limits.
▪ Lab, X-ray, Diagnostic Tests, Including Allergy Testing (Precertification may be required.) ▪ Injectible Medications	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Maternity Treatment (Prenatal and Postnatal)	90% of UCR.	90% of network rate after an initial visit copayment of $20; not subject to general deductible.	60% of UCR; subject to general deductible.
Outpatient Surgery in the Office Setting	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Allergy Shots and Serum	90% of UCR; subject to general deductible.	100% for shots and serum; not subject to the general deductible. (If physician is seen, visit is treated as an office visit subject to the per visit copayment of $20.)	60% of UCR; subject to general deductible.

Schedule of Benefits
Benefits For You and Your Dependents

Covered Services	July 1, 2000 High Option Plan The Plan Pays:	Standard PPO Plan In-Network The Plan Pays:	Standard PPO Plan Out-of-Network The Plan Pays:
Physician Services Furnished in a Hospital (Precertification is required.) ▪ Surgery (including charges by Surgeon, Anesthesiologist, Pathologist, and Radiologist)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Well-Newborn Care	Not covered.	100% of network rate.	Not covered.
Outpatient Surgery—Facility	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Hospital Services Other than those for Emergency Room Care ▪ Inpatient Care (including inpatient short-term rehabilitation services) Precertification is required. ▪ Well-Newborn Care	90% of UCR; subject to a per admission deductible of $100. 90% of UCR; subject to a per admission deductible of $100.	90% of network rate; subject to general deductible. 100% of network rate.	60% of UCR; subject to general deductible. Not covered.
▪ **Outpatient Services**	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Care in a Hospital Emergency Room **Treatment of an Emergency Medical Condition or Injury**	90% of UCR after a per visit copayment of $60. The copayment is reduced to $40 if referred by NurseCall 24. The copayment is not charged if admitted within 24 hours; coinsurance and hospital deductible apply.	90% of network rate after a per visit copayment of $60. The copayment is reduced to $40 if referred by NurseCall 24. The copayment is not charged if admitted within 24 hours; coinsurance and general deductible apply.	60% after a per visit copayment of $60. The copayment is reduced to $40 if referred by NurseCall 24. The copayment is not charged if admitted within 24 hours; coinsurance and general deductible apply.
Urgent Care Services (in an approved urgent-care center)	90% of UCR; subject to general deductible.	100% of network rate after a per visit copayment of $35; not subject to a general deductible.	80% of UCR; subject to general deductible.
X-rays and Laboratory Services (from an approved provider)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.

Schedule of Benefits
Benefits For You and Your Dependents

Covered Services	July 1, 2000 High Option Plan The Plan Pays:	Standard PPO Plan In-Network The Plan Pays:	Standard PPO Plan Out-of-Network The Plan Pays:
Prescription Drugs (Penalty may apply for brand-name drug if provider does not specify brand name.)	90% of network rate; subject to general deductible.	90% of network rate; subject to general deductible.	90% of network rate; subject to general deductible.
Skilled Nursing Facility Services	Not covered.	Not covered.	Not covered.
Home Nursing Care (Limited to [$7,500] per year; plan approved Letter of Medical Necessity is required. If in lieu of hospitalization, additional benefits may be approved.)	90% of UCR; subject to general deductible. (Two hours of care in a 24-hour day.) Expenses do not apply to annual out-of-pocket maximum.	90% of network rate; subject to general deductible. (Two hours of care in a 24-hour day.) Expenses do not apply to annual out-of-pocket maximum.	60% of UCR; subject to general deductible. (Two hours of care in a 24-hour day.) Expenses do not apply to annual out-of-pocket maximum.
▪ Home Hyperalimenation (must be precertified; lifetime benefit limit of $500,000)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Hospice Care (Precertification is required; if in lieu of hospitalization, additional benefits may be approved.)	100%; subject to general deductible and to hospital deductible if in lieu of hospitalization.	100% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Ambulance Services (medically necessary emergency transportation only)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Durable Medical Equipment (Plan approved Letter of Medical Necessity is required.)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Outpatient Self-Management Training and Educational Services ▪ Diabetes, Oncology, Congestive Heart Failure, and Asthma	100% of negotiated rate; not subject to general deductible; covered only when participating in approved disease state management program.	100% of negotiated rate; not subject to general deductible; covered only when participating in approved disease state management program.	Not applicable; covered only when participating in approved disease state management program.
Outpatient Short Term Rehabilitation Services (Physical, speech, cardiac, and occupational therapies are each limited to 40 visits per year.)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Treatment of TMJ (Diagnostic testing and nonsurgical treatment limited to $1,100 lifetime maximum.)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.
Chiropractic (limited to 40 visits per year)	90% of UCR; subject to general deductible.	90% of network rate; subject to general deductible.	60% of UCR; subject to general deductible.

Schedule of Benefits
Benefits For You and Your Dependents

Covered Services	July 1, 2000 High Option Plan The Plan Pays:	Standard PPO Plan In-Network The Plan Pays:	Standard PPO Plan Out-of-Network The Plan Pays:
Inpatient Behavioral Health—BHS Certification Required ▪ Facility Charges (Limited to 60 combined mental health and substance abuse days per plan year; substance abuse coverage limited to three episodes per lifetime.)	90% of network rate with BHS referral; 60% of network rate without BHS referral; not covered without BHS certification; subject to hospital deductible of $100.	90% of network rate with BHS referral; 60% of network rate without BHS referral; not covered without BHS certification; subject to hospital deductible of $100.	Not applicable; BHS benefits are carved out of PPO provider network.
▪ Partial Hospitalization (PH) and Intensive Outpatient (IOP) Charges (limited to 30 combined PH and IOP visits/days per year)	90% of network rate with BHS referral; not covered without BHS referral; subject to hospital deductible of $100.	90% of network rate with BHS referral; not covered without BHS referral; subject to hospital deductible of $100.	Not applicable; BHS benefits are carved out of PPO provider network.
▪ Physician Charges (Visit limitations represent a combined total of mental health and substance abuse visits.)	80% of network rate with BHS referral; limited to 60 visits per plan year; 50% of network rate without BHS referral; limited to 25 visits per year; subject to general deductible.	80% of network rate with BHS referral; limited to 60 visits per plan year; 50% of network rate without BHS referral; limited to 25 visits per year; subject to general deductible.	Not applicable; BHS benefits are carved out of PPO provider network.
Outpatient Behavioral Health (Visit limitations represent a combined visit total for mental health, substance abuse, and brief-visit therapy.)	80% of network rate with BHS referral; limited to 50 visits per year; 50% of network rate without BHS referral; limited to 25 visits per year; subject to general deductible.	80% of network rate with BHS referral; limited to 50 visits per year; 50% of network rate without BHS referral; limited to 25 visits per year; subject to general deductible.	Not applicable; BHS benefits are carved out of PPO provider network.
Brief-Visit Therapy (limited to three visits per year)	100%; not subject to general deductible.	100%; not subject to general deductible.	Not applicable; BHS benefits are carved out of PPO provider network.
Organ and Tissue Transplants (Prior approval is required.)	90% of network rate at contracting centers; 60% of UCR at noncontracting centers.	90% of network rate at contracting centers; 60% of UCR at noncontracting centers.	Not applicable; transplant benefits are carved out of PPO provider network.

SHBP Program Statistics:

	FY2001 YTD	FY2000	FY1999	FY1998
Member Statistics				
Employees (Contracts)[1]	203,125	203,069	203,841	204,639
Enrollees (Total Lives)[2]	398,411	403,561	409,987	414,310
Retired Enrollees				
Retirees	56,079	54,184	51,451	50,235
Dependents	22,899	22,577	21,226	20,683
Eligible for Medicare	37,619	36,210	34,730	33,981
Claims Statistics				
Total Claims (All Media)	4,670,874	8,099,793	8,304,826	7,920,957
Total Paper Claim	1,217,342	2,361,387	2,892,941	2,852,847
Total Rx Electronic Claims	2,075,542	3,504,171	3,516,982	3,389,467
Call Volume				
Member Phone Calls	303,000	362,048	495,169	500,323
Provider Helpline Phone Calls	202,500	251,592	344,102	293,585
Additional Statistics				
Organ Transplants (Network)	10	40	26	33
Inpatient Certifications (UM)	11,363	23,346	24,987	26,333
Outpatient Certifications (UM)	19,351	39,132	35,781	33,307
Cases Managed Certifications (UM)	1,048	2,307	2,323	2,366
Inpatient & Outpatient (BHS)	5,047	8,636	19,654	14,354
Emergency Room Waivers[3]	N/A	N/A	N/A	N/A

[1] *Represents Standard and High Option Enrollees(PPO implemented 7/1/2000)*

[2] *Represents Standard and High Option Enrollees(PPO implemented 7/1/2000)*

[3] *Program began on 7/1/97*

Appendix E—Board of Regents Health Program (BORHP)

Program Description:

The Board of Regents Health Plan (BORHP) is a health benefit plan administered by the Board of Regents covering more than 90,000 University System of Georgia employees, their dependents, and retirees.

Background:

Through a contract with the Department of Community Health (DCH), the DCH is responsible for the coordination of health care purchasing on behalf of the health benefit plan of the Board of Regents (BOR).

Funding:

There are three types of funding options for the BORHP:

1. HMO options that are fully insured
2. Preferred Provider Options (PPO and Consumer Choice Option) that represent a self-insurance arrangement
3. Indemnity Option, a self-insured arrangement utilizing a Georgia provider network provided by Blue Cross Blue Shield of Georgia

Summary of Benefits:

See the following pages.

External Vendors:

- Utilization Management
- Behavioral Health
- Emergency Room Waiver
- Pharmacy Benefit Manager
- Decision Support System
- Provider Networks (one for indemnity and one for PPO)

SCHEDULE OF SELECTED BENEFITS
Comparison of Current Board of Regents Health Indemnity Plan and New Plan Options
Effective January 1, 2001

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
COVERED SERVICES				
Description of Plan	Major medical coverage, including diagnosis and/or treatment of illness, injury, or medical conditions. Benefits include physician, hospital, surgical, prescription drug, and mental health/substance abuse services.	Major medical coverage, including diagnosis and/or treatment of illness, injury, or medical conditions. Benefits include physician, hospital, surgical, disease state management, pharmacy benefit management, mental health/substance abuse, and transplant services.	Major medical coverage, including diagnosis and/or treatment of illness, injury, or medical conditions. Benefits include physician, hospital, surgical, disease state management, pharmacy benefit management, behavioral health (mental health/substance abuse), and transplant services.	Major medical coverage, including diagnosis and/or treatment of illness, injury, or medical conditions. Benefits include physician, hospital, surgical, and pharmacy benefit management services.
Providers of Medical/Pharmacy Benefit Management Services	Physicians accept UCR fees as maximum payment for services. Members will not be subject to balance billing. The DCH has signed contracts with State of Georgia acute care hospitals. Payment for services is based on negotiated DRG rates.	Physicians accept UCR fees as maximum payment for services. Members will not be subject to balance billing. The DCH has signed contracts with State of Georgia acute care hospitals. Payment for services is based on negotiated DRG rates.	A PPO is a network of preferred doctors, hospitals, and other providers that have agreed to offer quality medical care and services at discounted contracted rates. The DCH has signed contracts with State of Georgia acute care hospitals. Payment for services is based on negotiated DRG rates.	When a member requires medical care/services, he/she can elect to see providers who are not in the PPO network. Members who elect to use the services of out-of-network doctors and hospitals will receive a lower level of benefit coverage. These members will be subject to balance billing for out-of-network doctor/hospital charges.

Providers of Medical/Pharmacy Benefit Management Services		Unicare administers the Disease State Management and Transplant Programs. Express Scripts administers the Pharmacy Benefit Management Program.	The PPO network, MRN/Georgia First, includes more than 9,300 physicians, 169 hospitals and ancillary facilities, and a comprehensive chiropractic network. The PPO network also includes doctors and hospitals near the Georgia border in Alabama, Florida, South Carolina, and Tennessee. PPO provider directories are available on the Internet at www.healthygeorgia.com The MRN/Georgia First in-network coverage area includes: (1) the State of Georgia; and (2) network providers located within 25 miles of the Georgia border. Unicare administers the Disease State Management and Transplant Programs. Express Scripts administers the Pharmacy Benefit Management Program.	Express Scripts administers the Pharmacy Benefit Management Program.

Providers of Behavioral Health Services (Mental Health and Substance Abuse)	The University System of Georgia uses the Blue Cross Blue Shield of Georgia Prudent Buyer Program for mental health and substance abuse services. Unicare requires precertification.	The University System of Georgia uses the Blue Cross Blue Shield of Georgia Prudent Buyer Program for mental health and substance abuse services. Unicare requires precertification.	The University System of Georgia uses the Magellan/Green Spring statewide network of physicians, healthcare professionals, and hospitals for mental health and substance abuse services. Magellan/Green Spring has agreed to offer quality mental health and substance abuse services at discounted contracted rates. Magellan/Green Spring provides 24-hour, toll-free, telephone access to clinical assessment and referral services for treatment/care of mental health/substance abuse conditions. Precertification is required by Magellan/Green Spring.	Not applicable.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
PLAN DESIGN FEATURES				
Maximum Lifetime Benefit Amount of Coverage	$1 million	$2 million	$2 million	$2 million
Annual Deductible/Copayments:				
Individual Maximum	$200	$300	$300	$400
Family Maximum	$400	$900	$900	$1,200
Note: We encourage PPO participants to use in-network provider services. Members who use both PPO in-network and out-of-network providers will be responsible for two **separate** deductibles. These individuals must meet both the in-network **and** out-of-network deductibles/out-of-pocket maximums. Annual deductibles and out-of-pocket maximums will be based on a January 1 to December 31 plan year.				
Annual Out-of-Pocket Maximums (Stop-Loss):				
Individual Maximum	$1,000	$2,000	$1,000	$2,000
Family Maximum	$2,000	$4,000	$2,000	$4,000
Note: We encourage PPO participants to use in-network provider services. Members who use both PPO in-network and out-of-network providers will be responsible for two **separate** deductibles. These individuals must meet both the in-network **and** out-of-network deductibles/out-of-pocket maximums. Annual deductibles and out-of-pocket maximums will be based on a January 1 to December 31 plan year.				
Preexisting Conditions	None.	None.	None.	None.
Chiropractic Care	Not available.	Not available.	90% of network rate; subject to deductible. Limited to 40 visits per year.	60% of network rate; subject to deductible. Limited to 40 visits per year.
Behavioral Health Services—PPO Magellan/Green Spring ▪ Annual Out-of-Pocket Maximum (Stop-Loss)			$2,500 per patient per calendar year for referred network care.	Not applicable.

PHYSICAN SERVICES PROVIDED IN OFFICE SETTING				
Physician Office Visit ▪ Treatment of Illness or Injury	80% of UCR charges for nonsurgical services; subject to deductible.	80% of UCR charges for nonsurgical services; subject to deductible.	100% of network rate after $20 copayment per visit; applies to nonsurgical services; not subject to deductible.	60% of network rate for nonsurgical services; subject to deductible.
Wellness Care/Preventive Health Care ▪ Physical Exam ▪ Mammogram ▪ Pap Smear ▪ Prostrate Exam/PSA ▪ Well-Baby Care and Immunizations ▪ Adult Immunizations ▪ Routine Eye Exams ▪ Routine Hearing Exams	$500 per person per plan year; paid at 100% of UCR; not subject to deductible.	$500 per person per plan year; paid at 100% of UCR; not subject to deductible.	$500 per person per plan year; paid at 100% of network rate; not subject to deductible. $20 copayment per office visit.	Not covered. Charges do not apply to annual deductible or annual out-of-pocket maximum.
Laboratory Services (Exclusive of Wellness Care/Preventative Health Care) ▪ X-ray ▪ Allergy Testing ▪ Injectible Medications ▪ Diagnostic Tests Precertification may be required.	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Maternity Care (Prenatal and Postnatal)	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	90% of network rate after an initial visit copayment of $20; not subject to deductible. There will be no copayments charged for subsequent visits.	60% of network rates; subject to deductible.
Outpatient Surgery Precertification may be required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.
Allergy Shots & Serum	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	100% for allergy shots and serum; not subject to deductible. If physician is seen, visit is treated as an office visit and is subject to $20 copayment per visit.	60% of network rate; subject to deductible.
Second and Third Surgical Opinions (Elective Surgery)	100% of UCR charges; not subject to deductible.	100% of UCR charges; not subject to deductible.	100% of network rate after $20 copayment per visit; not subject to deductible.	60% of network rate; subject to deductible.
Treatment of TMJ (Temporomandibular Joint Disorders) ▪ Diagnostic Testing and Nonsurgical Treatment	80% of UCR charges; subject to deductible. Lifetime benefit limit of $1,000.	80% of UCR charges; subject to deductible. Lifetime benefit limit of $1,000.	90% of network rate; subject to deductible. Lifetime benefit limit of $1,100.	60% of UCR charges; subject to deductible. Lifetime benefit limit of $1,100.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
INPATIENT HOSPITAL SERVICES				
Physician Services ▪ Physician Care/Surgery Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care/delivery. Precertification is required.	90% of UCR charges for attending physician or surgeon; subject to deductible. 80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; subject to deductible.	90% of UCR charges for attending physician or surgeon; subject to deductible. 80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; subject to deductible.	90% of network rate; subject to deductible. Some hospital based physicians providing services may not be a part of the network. Services provided by non-network physicians will be covered at 60% of network rate; subject to out-of-network deductible.	60% of network rate; subject to deductible.
▪ Well-Newborn Care (covered by Wellness Care/preventive health care subject to $500 limit per year)	100% of UCR charges; not subject to deductible.	100% of UCR charges; not subject to deductible.	100% of network rate; not subject to deductible.	Not covered. Charges do not apply to annual deductible or annual out-of-pocket maximum.
Hospital Services Other than those for Emergency Room Care ▪ Inpatient Care (includes inpatient short term rehabilitation services) Precertification is required.	90% of contracted DRG rate; subject to deductible. <u>Out-of-state hospitals</u>: 90% of UCR charges for service area; limited to semiprivate room rate; subject to deductible. Not subject to balance billing.	90% of contracted DRG rate; subject to deductible. <u>Out-of-state hospital:</u> 90% of UCR charges for service area; limited to semiprivate room rate; subject to deductible. Not subject to balance billing.	90% of contracted DRG rate; subject to deductible. <u>Out-of-state hospitals</u>: See section heading, Providers of Service, PPO In-Network, Page Two. Not subject to balance billing.	60% of contracted State of Georgia DRG rate; subject to deductible and balance billing. <u>Out-of-state hospitals</u>: 60% of contracted State of Georgia DRG rate; subject to deductible and balance billing.
Maternity Care (Delivery) Precertification is required.	90% of contracted DRG rate; subject to deductible.	90% of contracted DRG rate; subject to deductible.	90% of contracted DRG rate; subject to deductible.	60% of contracted DRG rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Laboratory Services ▪ X-ray ▪ Diagnostic Testing ▪ Lab Work (in conjunction with treatment of illness or injury) Precertification may be required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.
Hospice Care Precertification is required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	100% of network rate; subject to deductible.	60% of network rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
OUTPATIENT HOSPITAL/FACILITY SERVICES				
Physician Services ▪ Physician Care/Surgery Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care/delivery. Precertification may be required.	90% of UCR charges for attending physician or surgeon; subject to deductible. 80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; subject to deductible. Precertification is not currently required.	90% of UCR charges for attending physician or surgeon; subject to deductible. 80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.
Facility Selected by Treating Physician Precertification may be required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	90% of network rates; subject to deductible. Some facilities selected by a treating physician may not be a part of the network. Services provided at these non-network facilities will be covered at 60% of network rate; subject to out-of-network deductible.	60% of network rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Care in a Hospital Emergency Room (ER) ▪ Treatment of an Emergency or Medical Condition or Injury.	90% of UCR charges for surgical services; subject to deductible. 80% of UCR charges for nonsurgical services; subject to deductible.	90% of UCR charges for surgical services; subject to deductible if referred by MedCall. 80% of UCR charges for surgical services; subject to deductible if not referred by MedCall. 80% of UCR charges for nonsurgical services; subject to deductible, if referred by MedCall. 70% of UCR charges for nonsurgical services; subject to deductible if not referred by MedCall.	90% of network rate after $60 copayment per visit; subject to deductible. Copayment is reduced to $40 if referred by MedCall. Copayment is waived if admitted within 24 hours.	60% of network rate after $60 copayment per visit; subject to deductible. Copayment is reduced to $40 if referred by MedCall. Copayment is waived if admitted within 24 hours.
Laboratory Services ▪ X-ray ▪ Diagnostic Testing ▪ Lab Work (in conjunction with treatment of illness or injury) Precertification may be required.	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.
Urgent Care Services			100% of network rate after $35 copayment per visit; not subject to deductible.	80% of network rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Extended Care Facility An extended care facility is a skilled nursing facility qualified to receive Medicare payments or one that operates in accordance with local laws under the full-time supervision of a licensed nurse or doctor. It must provide room and board and 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness. Extended care facilities do not include an institution operated primarily for the care of the aged, treatment of mental disease, drug addiction, alcoholism, educational, or custodial care. Precertification is required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	Not available.	Not available.

Home Nursing Care Precertification is required.	90% of UCR charges; subject to deductible; no plan year limit.	90% of UCR charges; subject to deductible; no plan year limit.	90% of network rate; limited to two hours of care in a 24-hour day; subject to deductible. In lieu of hospitalization and with approval by Unicare, additional benefits may be allowed. Charges do not apply to annual out-of-pocket maximum. Limited to $7,500 per plan year; plan approved Letter of Medical Necessity required.	60% of network rate; limited to two hours of care in a 24-hour day; subject to deductible. Charges do not apply to annual out-of-pocket maximum. Limited to $7,500 per plan year; plan approved Letter of Medical Necessity required.
▪ Home Hyperalimenation Precertification is required.	90% of UCR charges; subject to deductible. No lifetime benefit limit.	90% of UCR charges; subject to deductible. No lifetime benefit limit.	90% of network rate; subject to deductible. Lifetime benefit limit of $500,000.	60% of network rate; subject to deductible. Lifetime benefit limit of $500,000.
Hospice Care Precertification is required.	90% of UCR charges; subject to deductible.	90% of UCR charges; subject to deductible.	100% of network rate; subject to deductible. In lieu of hospitalization and with approval by Unicare, additional benefits may be allowed.	60% of network rate; subject to deductible.
Ambulance Services (for medically necessary emergency transportation only)	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to general deductible.
Durable Medical Equipment Plan may require approved Letter of Medical Necessity.	80% of UCR charges; subject to deductible.	80% of UCR charges; subject to deductible.	90% of network rate; subject to deductible.	60% of network rate; subject to deductible.

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Outpatient Short Term Rehabilitation Services	80% of UCR charges; subject to deductible. Maximum of 12 consecutive weeks for physical/occupational therapy; maximum of 12 weeks per incident for cardiac therapy; no limitation for speech therapy.	80% of UCR charges; subject to deductible. Maximum of 12 consecutive weeks for physical/ occupational therapy; maximum of 12 weeks per incident for cardiac therapy; no limitation for speech therapy.	90% of network rate; subject to deductible. Physical, speech, cardiac, and occupational therapies are limited to 40 visits per incident type per year.	60% of network rate; subject to deductible. Physical, speech, cardiac, and occupational therapies are limited to 40 visits per incident type per year.

DISEASE STATE MANAGEMENT PROGRAM				
Disease State Management Training and Education Services Diabetes, Oncology, Congestive Heart Failure and Asthma Vendor: Unicare Precertification is required by Unicare	Disease State Management Program not offered.	100% of vendor negotiated rate; not subject to deductible.	100% of vendor negotiated rate; not subject to deductible.	Not applicable.

PHARMACY BENEFIT MANAGER				
Prescription Drugs Penalty will not be imposed if treating physician mandates preferred brand name drug or nonpreferred brand name drug Vendor: Express Scripts	80% of UCR charges; subject to deductible. Pharmacy Benefit Management (PBM) Program not offered.	3-Tier Copayment Structure Generic–$10 copayment; Preferred Brand Name–$20 copayment; and Nonpreferred Brand Name– 20% copayment of nonpreferred name brand drug cost; minimum member copayment of $35, maximum member copayment of $75. If the charge for a generic or preferred brand name drug is less than the copayment amount, the member will pay the lesser of the two. When a member chooses a brand name or nonpreferred brand name drug over its generic equivalent, the member will be responsible to "pay the difference" between the two in addition to the generic co-pay. If the treating physician mandates the brand or nonpreferred brand over the generic, the "pay the difference" feature will not apply. The member will only be responsible for the brand or nonpreferred brand copay. **Days Supply** There will be one copayment charged for a 30-day retail	3-Tier Copayment Structure Generic–$10 copayment; Preferred Brand Name–$20 copayment; and Nonpreferred Brand Name–20% copayment of nonpreferred name brand drug cost; minimum member copayment of $35, maximum member copayment of $75. If the charge for a generic or preferred brand name drug is less than the copayment amount, the member will pay the lesser of the two. When a member chooses a brand name or nonpreferred brand name drug over its generic equivalent, the member will be responsible to "pay the difference" between the two in addition to the generic copay. If the treating physician mandates the brand or nonpreferred brand over the generic, the "pay the difference" feature will not apply. The member will only be responsible for the brand or nonpreferred brand copay. **Days Supply** There will be one copayment charged for a 30-day retail	3-Tier Copayment Structure Generic–$10 copayment; Preferred Brand Name–$20 copayment; and Nonpreferred Brand Name–20% copayment of nonpreferred name brand drug cost; minimum member copayment of $35, maximum member copayment of $75. If the charge for a generic or preferred brand name drug is less than the copayment amount, the member will pay the lesser of the two. When a member chooses a brand name or nonpreferred brand name drug over its generic equivalent, the member will be responsible to "pay the difference" between the two in addition to the generic copay. If the treating physician mandates the brand or nonpreferred brand over the generic, the "pay the difference" feature will not apply. The member will only be responsible for the brand or nonpreferred brand copay. **Days Supply** There will be one copayment charged for a 30-day retail

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
		supply of a prescription drug. For those prescriptions that are defined as "maintenance drugs", there will be a 90-day supply limit permitted for a member. There will be one copayment charged for each 30-day period. For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior medical authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/tablets of medication per prescription. Not subject to deductible.	supply of a prescription drug. For those prescriptions that are defined as "maintenance drugs", there will be a 90-day supply limit permitted for a member. There will be one copayment charged for each 30-day period. For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior medical authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/tablets of medication per prescription. Not subject to deductible.	supply of a prescription drug. For those prescriptions that are defined as "maintenance drugs", there will be a 90-day supply limit permitted for a member. There will be one copayment charged for each 30-day period. For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior medical authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/tablets of medication per prescription. Not subject to deductible.

BEHAVIORAL HEALTH SERVICES				
Mental Health and Substance Abuse Inpatient Precertification is required.	90% of UCR charges; subject to deductible. Maximum benefit coverage of 60 days per person per plan year; 90 days per person per lifetime. Vendor: Blue Cross Blue Shield of Georgia. Precertification is required by Unicare.	90% of UCR charges; subject to deductible. Maximum benefit coverage of 60 days per person per plan year; 90 days per person per lifetime. Vendor: Blue Cross Blue Shield of Georgia. Precertification is required by Unicare.	Facility Charges–90% of network rate with vendor referral; subject to $100 hospital deductible. Facility Charges–60% of network rate without vendor referral; subject to $100 hospital deductible. Facility Charges–Maximum benefit coverage of 60 combined mental health and substance abuse days per person per plan year. Facility Charges–Substance abuse coverage limited to three episodes per lifetime. Precertification is required by Magellan/Green Spring. Partial/Day Hospitalization and Intensive Outpatient Charges–90% of network rate with vendor referral; subject to $100 hospital deductible.	Not applicable.

			Partial/Day Hospitalization and Intensive Outpatient Charges–Not covered without vendor referral. Partial/Day Hospitalization and Intensive Outpatient Charges–Maximum benefit coverage of 30 combined visits/days of partial day/hospitalization and intensive outpatient treatment per person per plan year. Physician Charges–80% of network rate with vendor referral; subject to deductible. Maximum of 60 visits per person per plan year. Physician Charges–50% of network rate without vendor referral; subject to deductible. Maximum of 25 visits per person per plan year. Vendor: Magellan/Green Spring.	

	Board of Regents 2000 Indemnity Plan	Board of Regents Indemnity Plan Effective January 1, 2001	Board of Regents Preferred Provider Option (PPO) Plan In-Network	Board of Regents Preferred Provider Option (PPO) Plan Out-of-Network
Behavioral Health Services Outpatient	80% of UCR charges; subject to deductible. Maximum benefit coverage of 20 visits per person per plan year. Unicare may approve up to 50 visits per year under the following conditions: (1) in lieu of inpatient treatment; or (2) immediately following hospital confinement for the same condition. Vendor: Blue Cross Blue Shield of Georgia.	80% of UCR charges; subject to deductible. Maximum benefit coverage of 20 visits per person per plan year. Unicare may approve up to 50 visits per year under the following conditions: (1) in lieu of inpatient treatment; or (2) immediately following hospital confinement for the same condition. Vendor: Blue Cross Blue Shield of Georgia.	80% of network rate with vendor referral; subject to deductible. Maximum benefit coverage of 50 combined mental health, substance abuse and brief-therapy visits per person per plan year. 50% of network rate without vendor referral; subject to deductible. Maximum benefit coverage of 25 combined mental health, substance abuse and brief-therapy visits per person per plan year. Vendor: Magellan/Green Spring.	Not applicable.
Behavioral Health Services Brief-Visit Therapy Brief-Visit Therapy is defined as a form of situation counseling featuring sessions that typically last 30 minutes or less. Applies only to PPO plan participants.			100% of network rate; limited to three visits per person per plan year; not subject to deductible. Vendor: Magellan/Green Spring.	Not applicable.

TRANSPLANT PROGRAM				
Organ and Tissue Transplants Expenses related to donor search not covered Precertification required by Unicare	90% of UCR charges for surgical services; subject to deductible. 80% of UCR charges for laboratory services; subject to deductible. Vendor: Blue Cross Blue Shield of Georgia	90% of vendor network rate at a Unicare contracted transplant center; subject to deductible and separate $100 hospital deductible. 60% of UCR charges at a non-contracted Unicare transplant center; subject to deductible and separate $100 hospital deductible. The list of Unicare contracted transplant centers will be provided. Lifetime benefit limit of $500,000. Vendor: Unicare	90% of vendor network rate at a Unicare contracted transplant center; subject to deductible and separate $100 hospital deductible. 60% of UCR charges at a non-contracted Unicare transplant center; subject to deductible and separate $100 hospital deductible. The list of Unicare contracted transplant centers will be provided. Lifetime benefit limit of $500,000. Vendor: Unicare	Not applicable.

BORHP Program Statistics:

	CY 2000	CY1999	CY 1998
Member Statistics			
Employees (Contracts)[1]	36,400	35,756	34,916
Enrollees (Total Lives)[2]	75,196	74,046	72,563
Retired Enrollees			
Retirees	8,341	7,997	7,597
Dependents	4,312	4,078	3,796
Also eligible for Medicare	5,627	5,548	5,442
Claims Statistics			
Total Claims (All Media)	2,219,687	2,017,898	1,823,375
Total Paper Claim	N/A	N/A	N/A
Total Rx Electronic Claims	N/A	N/A	N/A
Call Volume			
Member Phone Calls	204,000	153,000	150,000
Provider Helpline Phone Calls	N/A	N/A	N/A
Additional Statistics			
Organ Transplants (Network)	N/A	N/A	N/A
Inpatient Certifications (UM)	4,168	4,086	3,998
Outpatient Certifications (UM)	N/A	N/A	N/A
Cases Managed (UM) Certifications	1,006	977	943
Inpatient & Outpatient (BHS)[3]	276	251	278
Emergency Room Waivers	N/A	N/A	N/A

[1] *Represents PPO, CCO, and Indemnity Option enrollees but omits HMO enrollees*
[2] *Represents PPO, CCO, and Indemnity Option enrollees but omits HMO enrollees*
[3] *Represents Inpatient only*

Appendix F—Medicaid Program Description and Statistics

Program Description:

The DCH's Division of Medical Assistance (DMA) is responsible for the administration of the Medical Assistance Program in Georgia. The DMA is organized into sections responsible for general administration, legal and regulatory compliance, reimbursement services, systems management, program policy, and managed care.

The State of Georgia Medical Assistance Program (Medicaid) is a jointly funded cooperative venture between the federal government and the State. It enables the State to provide medical assistance to needy individuals. While federal law does not require states to cover prescription drugs as a 'basic service,' all states have included drug coverage as a covered 'optional service.' The Medicaid program is unique in many respects:

- Recipients qualify by meeting eligibility requirements based on being categorically needy (e.g., Aid to Families with Dependent Children, Supplement Security Income, children in families with incomes below certain thresholds) or medically needy.
- Recipients may enter and leave the program more than once during the year based on their ability to meet eligibility criteria.
- Recipients are typically classified by aid category (e.g., AFDC, aged, blind, disabled, Right From the Start Medicaid [RSM]).
- The Georgia Medicaid program currently covers approximately 1.3 million recipients.
- The Georgia Medicaid program allows participation by "any willing provider."

Eligibility:

To be eligible for Medicaid, a person must be aged (over 65); blind; permanently and totally disabled; a pregnant woman; or a child or a parent/caretaker of a Medicaid-eligible child. Also, the person must meet both the income and resource limits set for the appropriate category and any established non-financial requirements. Non-financial requirements include criteria such as age, U.S. citizenship or lawful alien status, and Georgia residency.

Major Coverage Groups:

- SSI Recipients–Aged, blind or disabled individuals who receive Supplemental Security Income (SSI).
- Nursing Home–Aged, blind or disabled individuals who live in nursing homes and have low income and limited assets.
- Community Care–Aged, blind or disabled individuals who need nursing home care but can stay at home with special community care services.
- Qualified Medicare Beneficiaries (QMB)–Aged or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.
- Hospice–Terminally ill individuals who are not expected to live more than six months may be eligible for coverage. Recipients must agree to receive hospice services through a Medicaid participating hospice care provider.
- Low Income Medicaid (LIM)–Adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.
- Right from the Start Medicaid for Pregnant Women (RSM Adults)–Pregnant women with family income at or below 200 percent of the federal poverty level.
- Right from the Start Medicaid for Children (RSM Children)–Children less than 19 years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family size.
- Medically Needy–Pregnant women, children and aged, blind and disabled individuals who have family income that exceeds the established income limit may be eligible under the Medically Needy program. The program allows persons to use incurred/unpaid medical bills to “spend down” the difference between their income and the income limit to become eligible.

Covered Services:

Ambulance Services
Ambulatory Surgical Services
Certified Registered Nurse Anesthetists
Childbirth Education Services
Children's Intervention Services
Diagnostic, Screening and Preventive Services (Health Departments)
Dental Services
Dialysis Services
Durable Medical Equipment Services
Family Planning Services
Georgia Better Health Care
Health Check (Early and Periodic Screening, Diagnosis and Treatment)
Health Insurance Premium Purchase Program (HIPP)
Health Insurance Premiums (Medicare Part A and Part B)
Home Health Services
Hospice Services
Inpatient and Outpatient Hospital Services
Intermediate Care for the Mentally Retarded Facility Services
Laboratory and Radiological Services
Medicare Crossovers
Mental Health Clinic Services
Non-Emergency Transportation Services
Nurse Midwifery Services
Nurse Practitioner Services
Nursing Facility Services
Oral Surgery Services
Orthotic and Prosthetic Services
Pharmacy Services
Physician Services
Physician's Assistant Services
Podiatric Services
Pre-Admission Screening/Annual Resident Review
Pregnancy-Related Services
Psychological Services
Rural Health Clinic/Community Health Center Services
Swing Bed Services
Targeted Case Management Services

- Adults with AIDS
- Children at Risk of Incarceration
- Chronically Mentally Ill
- Early Intervention
- Perinatal
- Adult and Child Protective Services

Therapeutic Residential Intervention
Vision Care Services
Waiver Services

- Community Care
- Independent Care
- Mental Retardation
- Model Waiver for Oxygen or Ventilator-Dependent Children
- Community Habilitation and Support
- Traumatic Brain Injury
- SOURCE (Service Options Using Resources in a Community Environment)

External Vendors:

Medicaid Fiscal Agent
Pharmacy Benefit Manager
Decision Support and Executive Information System Vendor
Hospital Pre-Certification Vendor
Nursing Home Pre-Admission Screening Vendor
Utilization Review Vendor
Third Party Liability Identification, Recovery (including Tort), and Health Insurance Premium Payment Vendor
Georgia Better Health Care Member Services Vendor
Department of Administrative Services (on behalf of DHR) Eligibility System PeachCare for Kids Eligibility Vendor

State of Georgia Medical Assistance Program Statistics:

	FY2001 YTD	FY2000	FY 1999	FY 1998
Member Statistics				
Adults	180,465	361,508	368,922	368,518
Children	283,449	581,748	604,740	609,568
Claims Statistics				
Total Claims (All Media)	17,635,961	36,226,252	35,190,757	34,017,776
Total Paper Claim	1,294,725	2,676,340	22,179,216	21,924,666
Total UB-92 Claims	742,637	1,585,938	1,558,175	1,483,762
Total HCFA 1500 Claims	7,266,113	15,123,806	15,353,620	14,770,679
Total Rx Electronic Claims	276,379	1,372,437	13,011,541	12,093,110
Call Volume				
Member Phone Calls	N/A	3,372,223	2,349,675	2,269,727
Provider Helpline Phone Calls	N/A	N/A	N/A	N/A

Appendix G—PeachCare for Kids

Program Description:

PeachCare for Kids provides uninsured children with access to affordable health care. To be eligible, children must be under age 19, uninsured, and live in households with incomes at or below 235 percent of the federal poverty level (about $40,000 a year for a family of 4). Children ages 6 and older pay $7.50 per child per month, or $15 per month for two or more children in the same household. Premiums are not required for children ages 5 and younger.

PeachCare for Kids was implemented statewide in January 1999. As of January 2001, over 114,000 of the estimated 143,000 eligible children were enrolled in PeachCare for Kids.

Background:

Title XXI of the Social Security Act was created by the Balanced Budget Act of 1997 to provide states with funding to cover uninsured children. States had the option of expanding Medicaid coverage or creating separate programs for children. The State of Georgia elected to create PeachCare for Kids, a separate state program that utilizes the Medicaid delivery system to provide health care services to enrolled children.

Summary of Benefits:

Children in PeachCare receive benefits similar to the children enrolled in RSM Medicaid, with the main exception of non-emergency transportation that is not available to children in PeachCare for Kids. Benefits include: regular physician check-ups and immunizations, inpatient and outpatient hospital services, dental care, mental health, prescription drugs and vision care. All children are enrolled in Georgia Better Health Care for primary care case management.

While the program has a monthly premium for some children, there are no copayments or deductibles for health care services.

External Vendors:

Dental Health Administrative and Consulting Services (DHACS) is the third party administrator for PeachCare for Kids. DHACS is responsible for processing PeachCare for Kids applications, collecting premiums, sending eligibility and enrollment notices to families, maintaining a member services call center, and coordinating Medicaid enrollment for children who apply for PeachCare for Kids and are determined to be eligible for Medicaid. DHACS maintains the eligibility database for PeachCare for Kids and is responsible for updating the claims vendor with the eligibility information.

Prospect Associates is the marketing and outreach vendor for PeachCare for Kids. Prospect is responsible for developing statewide major media campaigns and grassroots community outreach efforts.

PeachCare for Kids Program Statistics:

	FY2001 YTD	FY2000	FY 1999	FY 1998
Member Statistics				
Children	49,274	58,894	6269	Not Applicable
Claims Statistics				
Total Claims (All Media)	1,231,494	1,495,572	160,897	Not Applicable
Total Paper Claim	83,852	117,174	125,772	Not Applicable
Total UB-92 Claims	38,359	49,416	5,442	Not Applicable
Total HCFA 1500 Claims	847,472	1,013,240	111,646	Not Applicable
Total Rx Electronic Claims	1,924	6,776	35,125	Not Applicable
Total Other Claim types	63,641	75,380	8,684	Not Applicable
Call Volume				
Member Calls	N/A	450,323	342,267	Not Applicable

Appendix H—Project Stages, Milestones, and Deliverables

Each of the two Phases of this project, as defined in RFP Section 3.4, shall consist of several stages. For each project Phase, the Prime Contractor shall adhere to the stages, milestones, and deliverables described in this **Appendix H**.

Further, within each Phase, a percentage of the implementation costs for that Phase as bid in **Appendix L**, the Cost Proposal, shall be paid to the Prime Contractor within five (5) working days of each of the Payment Events as specified below. Stage IX, Post Implementation Evaluation; Corrections; Support Certification Process, shall be an exception to this payment timeframe; payment for Stage IX shall be made 90 calendar days after implementation of all services in scope for that Phase, assuming that all Stage IX milestones and deliverables have been accepted by DCH and assuming the Prime Contractor is substantially performing all of the services in the scope of that Phase at that time.

Also, shared implementation costs from **Appendix L** shall be deemed to be part of Phase I, Medicaid and PeachCare for Kids. If they are planned to be incurred by the Prime Contractor prior to October 1, 2002; otherwise, they will be deemed to be part of Phase II, SHBP and BORHP.

Payment Events

Contract execution: 5 percent
Acceptance by DCH of all milestones and deliverables in:

Stage I:	9 percent
Stage II:	10 percent
Stage III:	10 percent
Stage IV:	10 percent
Stage V:	8 percent
Stage VI:	8 percent
Stage VII:	10 percent
Stage VIII:	10 percent
Stage IX:	20 percent

Detailed work plans should be developed to include the following: stages, milestones and deliverables.

Stage I:

Initiate Project

During Stage I, the Prime Contractor will perform the following activities:

- Establish the project team that will be responsible for reviewing and defining all project requirements;
- Establish reporting requirements and communication protocols between DCH contract staff;
- Establish a temporary facility in Atlanta, Georgia to house the Prime Contractor, subcontractor staff, and equipment needed for the Implementation Stage activities;
- Prepare and provide, for DCH approval, a detailed implementation plan based on the work plan provided in the Prime Contractor's proposal;
- Provide DCH a list of the project management and automated analysis, design, development, and testing tools (i.e. CASE) to be utilized by the Prime Contractor and obtain DCH approval of the tools;
- Provide documentation of the development and testing methodology to be utilized during the implementation stage and obtain DCH approval;
- Install project management and automated analysis, design, development, and testing tools on the DCH system for use by state staff during implementation;
- Track and manage all change requests that evolve during the implementation stage;
- Prepare and provide, for DCH approval, a complete checklist matrix for data repository(s) hardware and software installation, network operations, system development activities, training activities, interface operations including the utilization of the interface engine, documentation activities, functional operations, and data conversion activities;
- Develop and provide, to DCH for approval, a preliminary plan for conversion of all DCH data;
- Prepare and provide, to DCH for review and approval, a comprehensive testing approach and plan for the entire DCH system and operations;
- Develop preliminary data security, disaster recovery, and backup and recovery procedures;
- Prepare and submit preliminary cost allocation plan to DCH for approval and submission to HCFA; the cost allocation plan must address the separation of any additional administrative costs associated with processing claims for Medicaid, PeachCare for kids, and, SHBP/BOR eligible members;
- Prepare and submit, for DCH approval, plans or procedures to be implemented for system change management;
- Work with DCH and their designated agent to integrate DCH re-engineering plan into implementation schedule and checklist;
- Incorporate re-engineering plans in overall technical and operational planning, provide for extra resource requirements as necessary, allow ample time for a coordinated information systems and re-engineering installation that is implemented in parallel and work effectively with any re-engineering contractor that is selected by the DCH; and,

- Conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Milestones

At a minimum, the following milestones have been identified for Stage I:

- Establishment of the temporary Prime Contractor and subcontractor implementation facility in Atlanta, Georgia;
- DCH approval of project management and automated analysis, design, development, and testing tools;
- DCH approval of the detailed implementation plan including an integrated re-engineering approach;
- DCH approval of the system development and testing methodology;
- DCH approval of preliminary conversion plan;
- DCH approval of preliminary data security, disaster recovery, and backup and recovery plan;
- DCH approval of preliminary cost allocation plan;
- DCH approval of the checklist matrix for implementation activities;
- Establish a data center;
- Operability of televideo conferencing equipment at DCH; and,
- DCH approval of testing methodology and approach to system and operational testing.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage I:

- Detailed implementation plan including an integrated re-engineering approach;
- Development and testing methodology;
- Checklist matrix for implementation activities;
- Preliminary conversion plan;
- Preliminary data security, disaster recovery, and backup and recovery plan;
- Preliminary cost allocation plan;
- Preliminary plan/procedures for system change management; and,
- Weekly project status reports.

Stage II:

Define/Finalize DCH User Requirements; Develop Functional Design

During Stage II, the Prime Contractor (with the subcontractors) will perform the following activities:

- Conduct a detailed requirements analysis for all DCH components and document findings;
- Update the detailed implementation plan, including integrated re-engineering approach, based on the findings of the requirements analysis and obtain DCH approval for the changes;
- Establish facilities for all local DCH components, including furnishing the facilities, installing hardware and software, and establishing all required telecommunication linkages. This includes providing connectivity to the Georgia Online Network (GO NET) as well as coordinating the DCH design with the DCH/DOAS internal network infrastructure;
- Prepare and provide to DCH a draft requirement analysis document including all data repository(s) and component area operational requirements;
- Conduct a walk through of the Requirements Analysis Document with DCH staff;
- Prepare the finalized Requirements Analysis Document and submit to DCH for approval;
- Establish complete database requirements and MIS structure including interface engine specifications, overall architecture and technology/specifications;
- Develop the logical and physical databases for the data repository(s);
- Establish the data repository(s), data center, and data communications network on the Prime Contractor's hardware;
- Prepare and provide to DCH a complete staffing plan for all components of the new DCH MIS;
- Work with DCH on planned re-engineering initiatives and integrate this and the DCH benefits realization plan into the Prime Contractor planning;
- Using the approved methodology, develop all component area system applications and software;
- Develop and test communication links between the System Integrator and all component area systems;
- Develop and test communication links between the Prime Contractor and DCH;
- Prepare and submit to DCH for approval the finalized data security, disaster recovery, and backup and recovery plan; and,
- Conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Milestones

At a minimum, the following milestones have been identified for Stage II:

- DCH approval of the updated detailed implementation plan;
- DCH approval of the requirements analysis document; which shall include the items identified as deliverables stage II through IX below and incorporate an integrated re-engineering approach and benefits realization plan;
- DCH approval of staffing plan;
- Establish facilities for all MMIS components; and,
- DCH approval of finalized data security, disaster recovery, and backup and recovery plan.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage II:

- Updated detailed implementation plan, with an integrated re-engineering approach and benefits realization plan;
- MIS architecture specifications;
- Design overview document;
- Hardware/software platform configuration chart;
- Internal data structures, data flow and process flow diagrams;
- Events and entity relationships with entity relationship diagram;
- Comprehensive list of input files and tables;
- Business information models for all component areas;
- Information system models for all component areas;
- Requirements analysis document component area functional requirements;
- Finalized security, disaster recovery, and backup and recovery plan;
- Weekly project status reports; and,
- Conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Stage III:

Develop Preliminary and Detail Designs; Technical Construction; Create Test Plans; Start Design Documentation

During Stage III, the Prime Contractor with his subcontractors, will perform the following activities:

- Update the detailed implementation plan with integrated re-engineering approach and benefits realization plan, and obtain DCH approval of the changes;
- Provide a detailed description and presentation of the system architecture documentation for the data repository(s) and platform with GTA, DCH and the BOR, and obtain approval of the proposed system design, development, and implementation methodology;
- Prepare and provide, for DCH approval, detailed design documentation for any specialty component systems and operations, and provide the documentation to and GTA, DCH/BOR for approval;
- Provide a detailed description and presentation of the detailed design documentation for any specialty component systems and operations with DCH and obtain DCH approval for the detailed design;
- Prepare and obtain GTA, DCH/BOR approval of a complete testing plan for integration testing, acceptance testing, and operations readiness/operability testing;
- Prepare and obtain DCH/BOR approval of the final test scenarios and the data to be used in acceptance testing;
- Develop test plans for process designs;
- Prepare and provide documentation of the overall technical system architecture, the data views for the other subcontractors, the data dictionary, overall system operation, security, and automated interfaces. Each of the subcontractors will be responsible for providing the system documentation relevant to their individual applications. The Prime contractor/systems integrator is responsible for coordinating documentation requirements with any subcontractors and ensuring that documentation is received according to documentation deadlines and is maintained up to date, stored using document imaging and workflow technology and usable on the WAN and LAN networks; and,
- Conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Milestones

At a minimum, the following milestones have been identified for Stage III:

- DCH/BOR approval of updated detailed implementation plans;

- DCH/BOR approval of detailed design documentation;
- DCH/BOR approval of overall MIS operations testing plan; and,
- GTA/DCH/BOR approval of system architecture documentation.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage III:

- Updated detailed implementation plans including integrated re-engineering approach and benefits realization plan;
- Detailed design documentation for each specialty component;
- Complete testing plan(s);
- Process design testing plan(s);
- System architecture documentation; and,
- Weekly project status reports.

Stage IV:

Test Individual Applications; Finish Design Documentation

During Stage IV, the Prime Contractor with his subcontractors will perform the following activities:

- Update the detailed implementation plans, including an integrated re-engineering approach and benefits realization plan, and obtain DCH/BOR approval of the changes;
- Prepare and provide to DCH/BOR finalized system, procedural, and user documentation for all specialty components including changes due to re-engineering and process design;
- Finalize the test plans for process design;
- Prepare and provide for DCH/BOR approval procedural manuals for performance of all component area functions including re-engineering changes;
- Test application modules for each component area;
- Prepare and deliver application test results for DCH/BOR review and approval;
- Make corrections to application errors identified by DCH/BOR or its designated agent, based on the review of application module test results; and,
- Conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Milestones

At a minimum, the following milestones have been identified for Stage IV:

- DCH approval of updated detailed implementation plans;
- DCH approval of system and user documentation for all MIS components;
- DCH approval of procedural manuals;
- DCH approval of process design testing plan; and,
- DCH approval of application module system test results.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage IV:

- Updated detailed implementation plans;
- Finalized procedures documentation for all MIS components;
- Finalized user documentation for all MIS components, including re-engineering and benefits realization;
- Finalized system documentation for all MIS components;
- Finalized process design test plan; and,
- Weekly project status reports.

Stage V:

Test Integrated System

During this Stage the Prime Contractor with his subcontractors will perform the following activities:

- Update the detailed implementation plans and obtain DCH approval of all changes;
- Perform integration testing of all system components utilizing the interface engine; and,
- Modify system design documentation and/or user documentation based on integrated system test results (if necessary).

Milestones

At a minimum, the following milestones have been identified for Stage V:

- DCH approval of the updated Detailed implementation plans;
- Completion and documentation of system integration test;
- DCH approval of Integration Test Results;
- DCH approval of finalized system documentation; and,
- DCH approval of finalized user documentation (modified if necessary based on test results).

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage V:

- Updated detailed implementation plans;
- Finalize system documentation for all MIS components;
- Finalized user documentation (modified if necessary based on test results); and,
- Weekly project status reports.

Stage VI:

Finalize and Test Conversion Plan; Finalize Plan for Acceptance Testing

During Stage VI, the Prime Contractor with his subcontractors will perform the following activities:

- Update the detailed implementation plans and obtain DCH approval of the changes;
- Perform initial data conversion from the current MIS to the new data repository(s). As data structures are refined, data conversion will be re-evaluated and constantly tested to ensure accurate codes and values as these are defined and used by the subcontractors;
- Finalize the testing plan and schedule for acceptance testing and operations readiness/operability testing. This test plan should outline the Prime Contractors approach to testing the entire MMIS, technical infrastructure and Medicaid operations, and reengineering approach; and,
- At the first in-process review (IPR), conduct weekly status meetings and provide weekly status reports using the approved project management tools.

Milestones

At a minimum, the following milestones have been identified for Stage VI:

- DCH approval of the updated detailed implementation plans;
- DCH approval of the finalized acceptance testing and operations readiness/operability testing plan;
- Establishment of acceptance testing environment; and,
- DCH approval of acceptance test scenarios.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage VI:

- Updated detailed implementation plans;
- Finalized Acceptance Testing and Operations Readiness/Operability Testing Plan;
- Test Scenarios for all acceptance testing and operations readiness/operability testing; and,
- Weekly project status reports.

Stage VII:

Provide Plans for Training and Operational Readiness; Train Staff

During Stage VII, the Prime Contractor, with his subcontractors, will perform the following activities:

- Update the detailed implementation plans and obtain DCH approval of all changes;
- Develop and provide, to DCH for approval, preliminary training plans for DCH and Prime Contractor staff which will include preparing both DCH and contractor staff for re-engineered processes;
- Train DCH and consultant staff who will participate in the acceptance testing;
- Schedule DCH, consultant, and Prime Contractor staff for the acceptance testing stage;
- Finalize acceptance testing checklist for all testing activities;
- Prepare acceptance test environment and load acceptance test data sets;
- Prepare training plans, procedures, user manuals, and process designs for re-engineering;
- Hire and train Prime Contractor staff for all MMIS components in preparation for acceptance testing activities and operations; and,
- Train all DCH staff in the operation of the new MIS and in the procedures for accessing and utilizing MMIS data.

Milestones

At a minimum, the following milestones have been identified for Stage VII:

- DCH approval of the updated detailed implementation plans;
- DCH approval of preliminary training plans which includes preparing staffs for re-engineered processes;
- Completion of training for DCH and Prime Contractor staff who will participate in the acceptance testing; and,
- DCH approval of final acceptance testing checklist for all test phases.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage VII:

- Updated detailed implementation plans;
- Training plans for DCH and subcontractor staff which includes preparing staffs for re-engineered processes;
- Acceptance testing checklist; and,
- Weekly status report.

Stage VIII:

Acceptance Testing; Final Design Changes; and Implementation

During Stage VIII, the Prime Contractor and his subcontractors will perform the following activities:

- Update the detailed implementation plans and obtain DCH approval for all changes;
- Establish and test all facility security and data security at all facilities;
- Conduct acceptance testing. DCH anticipates that the acceptance testing will be an iterative process of testing, correction and re-testing, with test results provided to DCH. DCH will approve the test results as specific tests are conducted and the results are validated by DCH. When all acceptance testing results have been validated, DCH will provide written approval of the acceptance test;
- Provide acceptance test results to DCH for approval;
- Implement corrective action for all problems identified during acceptance testing
- Conduct operations readiness/operability testing. Approval of this testing will be conducted in the same manner as the approval process for the acceptance testing;
- Provide operations readiness/operability test results to DCH for approval
- Implement corrective action for all problems identified during operations readiness/operability testing;
- Conduct testing on process designs developed in concert with the MMIS re-engineering project;
- Provide process design test results to DCH for approval;
- Modify any system, user documentation, training materials, process designs or procedure manual for all changes based on test results. Deliver to DCH for review and approval;
- Establish and test the production environment;
- Perform final data conversion and provide DCH with the results for approval;
- Notify providers of the change to the new MMIS and any changes in billing procedures;
- Verify that all telecommunications and telephone lines for providers and members are operational;
- Prepare and submit, to DCH and HCFA for approval, the final cost allocation plan. The cost allocation plan must address the separation of any additional administrative costs associated with processing claims for CHIP eligible members;
- Obtain DCH approval to begin operations;
- Begin operations;
- Develop and obtain DCH approval of a post-implementation evaluation plan; and,
- Establish the post-implementation evaluation team.

Milestones

At a minimum, the following milestones have been identified for Stage VIII:

- DCH approval of updated detailed implementation plans;
- Completion of the process design for re-engineering testing;
- Completion of acceptance testing;
- DCH approval of acceptance test;
- DCH approval of the process design for re-engineering testing;
- Completion of operations readiness/operability testing;
- DCH approval of operations readiness/operability testing;
- DCH approval of any changes to system, user documentation or procedures manuals based on test results;
- Establishment of production environment;
- DCH approval of final data conversion;
- Completion of training for all DCH, Prime Contractor, and subcontractor staff;
- DCH approval to begin operation;
- DCH approval of post implementation evaluation plan;
- DCH approval of final cost allocation plan;
- HCFA approval of cost allocation plan; and,
- DCH approval of MMIS certification plan.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage VIII:

- Updated detailed implementation plans;
- Re-engineering process design test results;
- Acceptance test results;
- Operations readiness/operability test results;
- Modified, final user, system documentation, procedures and process manuals based on test results from acceptance testing;
- Formal application to DCH for award of operational status;
- Finalized cost allocation plan;
- Post implementation evaluation plan;
- MMIS certification plan; and,
- Weekly status report.

Stage IX:

Post Implementation Evaluation; Corrections; Support Certification Process

During Stage IX, the Prime Contractor (with his subcontractors), will perform the following activities:

- Update the Final Detailed implementation plans and obtain DCH approval for the changes;
- Conduct the post-implementation evaluation according to the approved plan including a re-engineering and benefits realization assessment;
- Produce a post-implementation evaluation report with includes a re-engineering and benefits realization assessment;
- Produce and implement a post-implementation corrective action plan
- Implement corrections;
- Develop and obtain DCH approval of MMIS certification plan;
- Prepare MMIS certification documentation; and,
- Provide support to DCH and HCFA staff during certification activities.

Milestones

At a minimum, the following milestones have been identified for Stage IX:

- DCH approval of the updated detailed implementation plans;
- Completion of the post-implementation evaluation according to the approved plan which includes a re-engineering and benefits realization assessment;
- Completion of a post-implementation evaluation report which includes a re-engineering and benefits realization assessment;
- Production and implementation of a post-implementation corrective action plan; and,
- Implementation of corrections.

Deliverables

The Prime Contractor will provide the following deliverables to DCH during Stage IX:

- Final detailed implementation plans;
- Approved post-implementation evaluation plans;
- Post-implementation evaluation report including re-engineering and benefits realization assessments;
- Post-implementation corrective action plan;
- Post-implementation corrections; and,
- Weekly status reports.

Appendix I—Performance Standards and Goals

Performance Standards and Incentives

The Prime Contractor will be subject to meeting performance standards. A comparison of the Prime Contractor's performance against these standards will be made periodically at a frequency to be specified by the DCH/BOR, but not more frequently than monthly.

The Prime Contractor will be expected to implement and operate an ongoing program for measuring and reporting its performance to the DCH/BOR against these standards. The DCH/BOR will specify standard performance measurement reports to be prepared by the Prime Contractor's quality assurance staff. The DCH/BOR may also audit these reports and conduct its own audits or have a qualified third party perform audits of Prime Contractor performance at its sole discretion. These audits may be used to validate the results of the Prime Contractor audit. The Prime Contractor will be accountable for resolving any disagreements between the Prime Contractor and the independent auditor that arise from an independent audit.

Further, as explained below under "Cost Savings Incentives," the DCH/BOR will provide incentives to the Prime Contractor to help the DCH/BOR reduce costs.

Implementation and Systems Architecture Performance Guarantee

I. Intent

The intent of this section is to establish measurable goals for the timely and successful implementation of the claims administration capabilities, including the attainment of the key procurement objectives described in Sections 1 and 3 of the RFP.

II. Performance Standards

Each of the following Performance Standards will be measured separately for the SHBP, BORHP, and Medicaid/PeachCare for Kids.

A. Goal: Substantial performance of Medicaid and PeachCare for Kids claims administration and customer services by October 1, 2002. Failure to obtain MMIS certification and/or to achieve HIPAA compliance will constitute failure to substantially perform and will result in the assessment of liquidated damages.

The consequences for failure to substantially perform will equal liquidated damages of $100,000 per day of delay.

B. Goal: Substantial performance of SHBP claims administration and customer services on or before July 1, 2003, and substantial performance of BORHP claims administration and customer service on or before January 1, 2004.

The consequences for failure to substantially perform will equal liquidated damages of $100,000 per day of delay.

C. Goal: Access to and ability to consolidate all DCH production data for all populations on a real-time or near real-time basis by October 1, 2003. Access to and ability to consolidate all BOR production data for all populations on a real-time basis on or before January 1, 2004.

The consequences for failure to substantially perform will equal liquidated damages of $10,000 per day of delay.

D. Goal: Achieve HIPAA compliance for all DCH health plan operations by October 1, 2002, prior to implementing the BORHP on or before January 1, 2004.

The consequences for failure to achieve compliance will equal payment of all incurred HIPAA consequences and liquidated damages of $10,000 per day of delay.

E. Goal: Provide single, electronic point of entry for all HIPAA transactions for all members and providers by October 1, 2002; no later than July 1, 2003, for SHBP; and no later than January 1, 2004, for BORHP Programs.

The consequences for failure to substantially perform will equal liquidated damages of $10,000 per day of delay.

Management of Other Contractors Performance Guarantee

I. Intent

The intent of this section is to establish quantifiable methods of measuring the effectiveness of the Prime Contractor's management of the DCH/BOR's overall health plan operations, including other DCH/BOR contractors, with the exception of Medstat and Express Scripts. Further, it is the intent of this section to provide the Prime Contractor with incentives to implement successful cost savings initiatives by sharing a portion of those savings with the Prime Contractor.

II. Performance Standards, Consequences, and Cost Savings Incentives

Each of the following Performance Standards will be measured separately for the SHBP, BORHP, and Medicaid/PeachCare for Kids.

A. Effectiveness Measure: Member and Provider Satisfaction

Performance Standard: After the first six months of operation for a given population (i.e., Medicaid and PeachCare for Kids or SHBP and BORHP), member and satisfaction survey results will show levels of satisfaction for the service support aspects of the program. The levels of satisfaction with these services must be at least as high as three months before the Prime Contractor initiates support for the population. Subsequently, satisfaction surveys conducted every six months will show statistically measurable improvements in satisfaction. The DCH/BOR and the Prime Contractor will agree on a mutually acceptable survey instrument, sample process, and survey timeframe. The survey will be performed, and the results will be tabulated and reported directly to the DCH/BOR by an independent third party. The cost of the survey should be included in the Prime Contractor's administrative fees.

The consequences for failure to meet standard will equal five percent of the fee for management services for the relevant benefit programs for measured six-month period.

B. Effectiveness Measure: Prime Contractor and the DSS Judgment of Overall Health Plan Operations

Performance Standard: After the first six months of operation for a given population (i.e., Medicaid and PeachCare for Kids or SHBP and BORHP), surveys of key DCH/BOR contractor managers will indicate that health plan operations are operating at least as well as three months before the Prime Contractor initiates support for the population. Subsequently, such surveys conducted every six months will show statistically measurable improvements in judgments of the performance of health plan operations. The DCH/BOR and the Prime Contractor will agree on a mutually acceptable survey instrument, sample process, and survey timeframe. The survey will be performed, and the results will be tabulated and reported directly to the DCH/BOR by an independent third party. The cost of the survey should be included in the Prime Contractor's administrative fees.

The consequences for failure to meet standard will equal five percent of the fee for management services for the measured six-month period.

C. Effectiveness Measure: Use of Management Best Practices

Performance Standard: Prime Contractor will comprehensively employ management best practices for all health plan operations and contractors under its responsibility, including the use of:

- Steering Committee meeting at least monthly
- Operations Committee meeting at least weekly by phone and monthly face to face
- Comprehensive work plans, issue and decision tracking system, and written weekly updates to the DCH/BOR management
- Comprehensive communications and documentation strategy, including use of web-based document server

The consequences for failure to meet standard will equal five percent of the fee for management services for the measured six-month period.

III. Cost Savings Incentives

Potential to share in cost savings–On an on-going basis, DCH may ask the prime contractor to implement cost savings initiatives. To the extent that these initiatives are able to produce significant, measurable cost savings, DCH may request that the prime contractor reduce its fees in recognition of those cost savings. However, as an incentive to the contractor to effectively implement the cost savings initiatives, DCH will share five (5) percent of the administrative (i.e. non-medical) cost reductions to the DCH/BOR achieved by the prime contractor. Assuming that these initiatives continue to produce cost savings over time, then the prime contractor will receive these shares of cost reductions for the life of the contract or as long as the initiative is still relevant to accomplishing the overall DCH/BOR business function, whichever is achieved first.

Claims Administration Performance Guarantee

I. Intent

The intent of this section is to establish quantifiable expectations relative to specific areas of plan claims administration. The Prime Contractor's performance against these expectations can then be factored into the DCH/BOR's analysis of administration quality.

The Prime Contractor and the DCH/BOR agree to the following consequences for failure to achieve the performance targets and resulting administration fee charge adjustments as provided for in the Agreement. Results will be calculated from monthly performance guarantee audits to be conducted by the Prime Contractor. All claims accuracy audits shall consider a random sample of five percent of the total claims processed during the applicable month selected using a methodology previously approved by the DCH/BOR. The Prime Contractor will present the results of its audit within 20 calendar days following the end of the month.

The results of each monthly audit will be reviewed in detail with the DCH and with the BOR prior to final calculation of performance results. Each party will be given an opportunity to address any error and either concur or disagree with the findings of the audit. A third party, who is agreeable to both parties, may be used to decide whether or not an error will be charged if the DCH and/or the BOR and Prime Contractor cannot come to agreement on any single item.

The DCH may reduce the value of administration fee payments to the Prime Contractor either prospectively or retrospectively at the DCH/BOR's sole discretion to the extent that the Prime Contractor is subject to consequences under the contract for failing to meet one or more performance standards during a given time period. Financial consequences will be based on a percentage of the administration fees due to the Prime Contractor for the same billing month(s) for which performance was measured.

II. Performance Standards

Each of the following Performance Standards will be measured separately for the SHBP, BORHP, and Medicaid/PeachCare for Kids.

A. Financial Accuracy

Performance Standard: 99 percent or higher

Financial Accuracy percentage will be calculated as the weighted average of absolute dollars paid correctly as determined by a financially stratified sampling methodology. The sample size and stratification will be structured to provide a level of precision of 2 percent at the 95 percent confidence interval.

B. Claim Payment Accuracy

Performance Standard: 97 percent or higher

Claim Payment Accuracy percentage will be calculated as the weighted average of claims paid correctly as determined by a financially stratified sampling methodology. The sample size and stratification will be structured to provide a level of precision of 3 percent at the 95 percent confidence interval. Only underpaid or overpaid claims which result solely from the failure of the Prime Contractor to properly process same are considered in this calculation. A single claim will be deemed to have no more than one error for calculating this accuracy category.

NOTE: In the event of an identified overpayment caused by the Prime Contractor, the DCH/BOR will request payment directly from the Prime Contractor and will require the Prime Contractor to recoup the funds from the providers.

C. Claim Turnaround Time:

Performance Standard: 100% of Clean Claims paid or denied within 7 days of receipt

The calculation for the Claim Turnaround Time percentage will be measured on the percentage of all Clean Claims processed within the number of calendar days from the date of receipt as listed above. Performance Standard will be tolled with respect to a claim during the period the claim is suspended for information outside the Prime Contractor's claims processing system or scope of responsibility or control (i.e., review by other organizations not integrated into processing system).

D. Customer Service Support

For all provider and member calls:

Performance Standard 1: 80 percent or more of calls answered within 30 seconds
Performance Standard 2: 90 percent or more of open inquiries closed within 72 hours
Performance Standard 3: abandoned rate of calls is five percent or less
Performance Standard 4: busy out rate is less than one percent

For all written correspondence:

Performance Standard: 100 percent of written correspondence must be mailed to the provider or member within 72 hours

For all e-mail or electronic responses to provider and member queries:

Performance Standard: 100 percent of all e-mail or other electronic responses to provider and member queries must be completed within 72 hours

III. Consequences for Failure to Perform:

Performance Measure	Reduction in Prime Contractor Monthly Invoice
Financial Accuracy	2.5%
Claim Payment Accuracy	1.5%
Claim Turnaround Time 1	2.0%
Customer Service Support 1	2.0%
Customer Service Support 2	2.0%
Customer Service Support 3	1.0%
Customer Service Support 4	1.0%
Customer Service Support–Written Correspondence	1.0%
Customer Service Support–Electronic Correspondence	1.0%

The failure to meet a Performance Standard, as specified herein, will result in a reduction in the Prime Contractor's monthly invoice as shown above for the relevant benefit program (SHBP, BORHP, or Medicaid/PeachCare for Kids). The DCH/BOR will receive credit for the assessed sum.